DANBURY HOSPITAL

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Written Testimony of Matthew Miller, M.D.,

Chief Medical Officer, on behalf of Danbury Hospital

Respectfully Submitted to the Public Health Committee March 1, 2010

Regarding Senate Bill 248 "An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities"

Danbury Hospital appreciates the opportunity to submit comments on Senate Bill 248. At Danbury Hospital, our unwavering commitment to quality care and patient safety is driven by the Board and demonstrated daily by our dedicated team of doctors, nurses and staff. We deploy multiple teams of personnel throughout the organization to monitor and improve patient safety and quality outcomes. Beyond our continual internal efforts, Danbury Hospital has had a long history of comprehensive reporting on patient outcomes to the community. In fact the same outcomes data that are reported to our Board are available to the public on our website at www.DanburyHospital.org.

We are consistently among the first to implement national patient safety best practices. Some examples of these practices are things such as Hospitalist and Intensivist programs, computerized physician order entry, electronic medical records, web-based informed consent/patient education modules, full-time chairmen covering all clinical services, and rapid response teams. We have totally revamped our Peer Review programs to provide centralized oversight, expedited case review, and timely attention to interdepartmental issues. We participate in multiple national quality data comparison programs to compare and improve our outcomes, such as NDNQI (The National Database of Nursing Quality Indicators), NSQIP (National Surgical Quality Improvement Program), ACC-NCDR (American College of Cardiology- National Cardiovascular Data Registry), to name just a few. Additionally, each year we invite external parties to conduct thorough reviews of our complex clinical areas to identify any opportunities for improvement.

We have been committed to developing and maintaining a strong patient safety culture, with a focus on responsibility and accountability. To strengthen this culture, we engaged in comprehensive work to bring ***"Just Culture"*** into the organization a number of years ago. This model of safety is based on accountability related to behavioral choices and safe system design. All employees are responsible for maintaining safe environments for our patients, and are expected to identify any individual or system issues that might interfere with this. Managers are expected to be open to safety improvement suggestions, coach or discipline employees on their behavior, and ensure safe system design in their areas of responsibility.

Last year, we implemented an electronic adverse event reporting system that allows for real time notification of actual or potential events. Any employee or medical staff member can report a safety concern or actual event in a very user friendly "click and send" manner. This automatically sends out notification to identified responsible parties, with an expectation for immediate attention and documented follow-up.

We've worked hard to promote an atmosphere of non-punitive reporting, and feel that our efforts have fostered an environment that has been recognized by national experts as promoting a strong patient safety culture. In this time when health care delivery is more complex than ever, it is imperative that our staff and medical staff willingly engage with us in these efforts, without fear of inappropriate punitive action or civil penalties. We have grave concern that the proposed amendments to the Adverse Event Reporting law will have a significant negative impact on these efforts.

Sincerely,

Matthew Miller, MD